New Jersey Department of Health and Senior Services

BABESIOSIS REPORT

Date	CDRS ID No.

Name (Last)	(First)	(MI)	Sex	Date of Birth (Age)

Street Address	County

City	State	Zip Code	Telephone Number

Race

☐ White ☐ American Indian ☐ Unknown/Other
☐ Black ☐ Asian

Ethnicity

☐ Hispanic ☐ Unknown
☐ Non-Hispanic

Reporting Physician (Name, Address and Telephone No.)	Hospital (Name, Address and Telephone No.)

Date of Diagnosis	**Onset Date of Illness**	**Deceased?**	Case Status
____ / ____ / ____	____ / ____ / ____	☐ Yes ☐ No ☐ Unknown	☐ Possible ☐ Probable ☐ Confirmed

Clinical:

Fever? ☐ Yes ☐ No Highest temp.: _____ Jaundice? ☐ Yes ☐ No

Splenomegaly? ☐ Yes ☐ No Anemia? ☐ Yes ☐ No

Other symptoms: _____

Risk Factors:

Tick exposure (within last 2 months)? ☐ Yes ☐ No ☐ Unknown

If yes, when: _____ Where (county or state if outside of NJ): _____

History of splenectomy? ☐ Yes ☐ No ☐ Unknown

If yes, when: _____

Recent blood transfusion? ☐ Yes ☐ No ☐ Unknown

If yes, when: _____ Where: _____

Was immunosuppressive condition (e.g., HIV, neoplastic disease or others) present? ☐ Yes ☐ No

If yes, specify: _____

Laboratory Tests (Describe or attach copy of lab reports.): Date of Specimen Collection

1. Blood smear positive for Babesia: ☐ Yes ☐ No ☐ Not Done ____ / ____ / ____
   (If Yes, please submit one diagnostic slide to PHEL in Trenton.)
2. Serological tests positive for Babesia: ☐ Yes ☐ No ☐ Not Done ____ / ____ / ____
   If yes, specify: _____
3. Other tests positive for *Babesia* (e.g., PCR): ☐ Yes ☐ No ☐ Not Done ____ / ____ / ____
   If yes, specify: _____

Comments:

Name and Title of Person Submitting Report	Telephone Number

CDS-7
JAN 03